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No. 80-419

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

STATE OF ARIZONA,

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION OF THE GRAY PANTHERS FOR PERMISSION TO FILE A BRIEF AMICUS CURIAE
and
BRIEF OF THE GRAY PANTHERS AS AMICUS CURIAE

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The Gray Panthers, through their undersigned counsel, moves pursuant to Rule 36, Rules of the United States Supreme Court, for permission to file a brief amicus curiae on a petition for a writ of certiorari in *State of Arizona v. Maricopa County Medical Society, et al.*, No. 80-419. Grounds for this motion are:

1. On September 16, 1980 the State of Arizona filed its petition for a writ of certiorari to the United States Court of Appeals for the Ninth Circuit. The question

presented is whether an agreement among competing physicians establishing fee schedules for their individual services is a *per se* violation of the Sherman Act.

2. The Gray Panthers is an association of persons who are dedicated to protecting the rights and interests of older persons in the United States. It has 42,000 members in the entire nation.

3. The elderly spend a disproportionate amount of their income on health care. Although the income of people over age 65 is substantially lower than that of younger adults, their declining health makes their expenditures for health services substantially higher than those of younger persons. Accordingly, the upward-spiraling inflation in health care costs in the past decade has had a particularly severe effect on the elderly: the Medicare program is leaving an increasingly large health care bill for the elderly to pay out of their own meager resources. In 1975 the elderly paid out of their pockets $398.88 per capita for health care, which is more than their total per capita expenditures in 1966 before the Medicare program went into effect, and twice as much as their expenditures during each of the first two years of the Medicare program's administration.[1]

4. The State of Arizona brought this action for declaratory and injunctive relief not only on its own behalf, but also on behalf of its resident citizens. More than 307,000 persons 65 years of age or older, including a substantial number of members of the Gray Panthers, reside and purchase doctors' services in Arizona.

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[1] "The Aged and Their Health Expenditures", prepared by staff of the Subcommittee on Health, House Select Committee on Aging, January, 1977.

5. Thus, the Gray Panthers has a legitimate and vital interest in the petition for a writ of certiorari before this Court and respectfully submit that its argument for the granting of that petition should be presented to and considered by this Court.

6. The Gray Panthers has been unable to obtain the consent of all parties involved in *State of Arizona v. Maricopa County Medical Society, et al.*, to the filing of an amicus curiae brief, thus necessitating this motion.

For the foregoing reasons, the Gray Panthers respectfully moves for permission to file a brief amicus curiae in support of the petition for a writ of certiorari in this matter.

Respectfully submitted,

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BRIEF OF AMICUS CURIAE
THE GRAY PANTHERS

INTEREST OF AMICUS CURIAE

The Gray Panthers respectfully submits this brief amicus curiae in support of the State of Arizona's petition for a writ of certiorari to the United States Court of Appeals for the Ninth Circuit pursuant to Rule 36, Rules of the United States Supreme Court.

The Gray Panthers is a group of persons concerned about the interests of the elderly whose members purchase a substantial amount of medical services in Arizona

and other states. Because like most senior citizens, elderly Gray Panthers generally subsist on fixed incomes, because Medicare covers less than half of their health care costs, and because private insurance to supplement Medicare does not pay for the growing difference between physician's actual charges and the Medicare allowances, any agreement affecting the price of medical services has a direct impact on the membership of the Gray Panthers.

Accordingly, the Gray Panthers has a direct and substantial interest in the question of whether an agreement among competing physicians establishing fee schedules for their individual services is a *per se* violation of the Sherman Act.

ARGUMENT

I.
THE NINTH CIRCUIT'S CREATION OF A SPECIAL ANTITRUST EXEMPTION FOR THE HEALTH CARE INDUSTRY IS A SERIOUS MISINTERPREATION OF THE SHERMAN ACT

In the portion of Judge Sneed's opinion endorsed by Judge Kennedy, the anticompetitive characteristics of the health care industry are taken as cause to exempt the health care industry from established standards of antitrust enforcement. This holding turns the Sherman Act on its head.

Congress has recognized the anticompetitive and inflationary characteristics cited in Judge Sneed's opinion,[1] and has attempted to remedy them.[2] But it has never

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[1] *See e.g.*, U.S. Code Cong. & Adm. News, Vol. 4, p. 7878.

[2] *E.g.*, 42 U.S.C. §300k, *et seq.* (national health planning and development); 42 U.S.C. §1395 *et seq.* (Medicare program for the elderly).

exempted the health care industry from the antitrust laws. To the contrary, in its recent amendment of the 1974 National Health Planning and Resource Development Act, Congress expressed its intention that competition should prevail in that industry.[3] Under these circumstances, Judge Sneed's argument that the special characteristics of the medical marketplace make monopolistic arrangements preferable to competition as a means of controlling prices is foreclosed by the will of Congress and the consistent holdings of this Court. *E.g., National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940).

Indeed, this Court and the lower federal courts have applied established antitrust analysis to the medical care industry with the acquiescence of Congress.[4] That the *per se* rule against price-fixing applies to interstate commerce in professional services has been well established.[5] By diverging from this unanimous authority and

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[3] 42 U.S.C. §300e *et seq.* (Supp. 1979).

[4] *American Medical Ass'n v. United States*, 317 U.S. 519 (1943); *Ballard v. Blue Shield*, 543 F.2d 1075 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977); *Feminist Women's Health Center, Inc. v. Mohammad*, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962); *Veigaga v. National Bd. of Respiratory Therapy*, 1977-1 CCH Trade Cas. ¶61,274 (N.D. Ill. 1977); *Cf., Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

[5] *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1979); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *United States v. National Ass'n of Real Estate Bds.*, 339 U.S. 485 (1950); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962); *United States v. Texas State Bd. of Public Accountancy*, 464 F. Supp. 400 (W.D. Tex. 1978), *aff'd*, 592 F.2d 919 (5th Cir.), *cert. denied*, 444 U.S. 925 (1979); *Vandervelde v. Put & Call Brokers & Dealers Ass'n*, 344 F. Supp. 118 (S.D.N.Y. 1972).

creating a judicial exemption for the medical profession, the Ninth Circuit seriously misinterpreted the Sherman Act. It disregarded the clear will of Congress by creating an antitrust exemption for an entire industry on the paradoxical ground that that industry exhibits grossly anticompetitive conditions.

As a result, Judge Sneed's opinion enunciates an unprecedented standard of proof, requiring that those injured by antitrust violations prove that prices would have been lower had the violation not occurred. It defines the key issue as the relative reasonableness of the prices fixed by the challenged agreement.

> In simplified economic terms, the issue is whether the maximum fee arrangement better permits the attainment of the monopolist's goal, *viz.*, the matching of marginal cost to marginal revenue, or in fact obstructs that end. Appendix A, Petition, at 6.

That simply is not "the issue" posed by the Sherman Act.

Under that Act consumers of health care are entitled to purchase and negotiate for doctors' services in an open, competitive marketplace. Whether or not an agreement among competing physicians on fee schedules for their individual services maximizes their monopoly profit it is unreasonable because it deprives consumers of the opportunity to negotiate at arm's length and to purchase medical services in an open, competitive marketplace.[6] That opportunity is protected by the Sherman Act and cannot be abrogated by the judiciary.

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[6] *National Society of Professional Engineers v. United States*, 435 U.S. 679, 689 (1978); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 212-224 (1940); *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397 (1927); *United States v. Trans-Missouri Freight Ass'n.*, 166 U.S. 290, 340-341 (1897).

II.
THE MEDICARE PROGRAM AND ITS BENEFICIARIES ARE DETRIMENTALLY AFFECTED BY THE PHYSICIANS' FEE SCHEDULES AT ISSUE HEREIN.

Judge Sneed based his opinion on certain assumed "anti-competitive characteristics" of the health care industry that he thought affected the appropriateness of free market price competition in the industry.[7] Although not clearly articulated, these assumptions presumably included the existence of the vast Medicare program, which provides health insurance to the aged. Any assumption that the Medicare program somehow justifies fee setting among physicians is completely wrong. As the Gray Panthers is keenly aware, Medicare reimbursement of physicians' fees, as designed by Congress, depends heavily on competition among physicians, both to keep overall program expenditures down and to provide the elderly with adequate levels of reimbursement of their costs for physicians' services.

The Medicare Act prescribes a system for payment of physicians' fees that assumes the existence of fee competition among physicians. Medicare Part B reimburses for physicians' fees on a "reasonable charge" basis: an amount which is the least of three charges, (1) the actual charge, (2) the "customary charge"[8] or (3) the "prevailing charge".[9] 42 U.S.C. Sec. 1392u(b), 42 C.F.R. §405.507.

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[7] Petition, Appendix A at 4-8.

[8] "Customary Charge" is defined by the Department of Health and Human Services in its regulations as the uniform amount charged by the individual physician in the majority of cases for a particular service. 42 C.F.R. §405.503(a).

[9] "Prevailing Charge" is defined by the Department of Health and Human Services as the lowest "customary charge" which is

[footnote continued]

In 1972, amendments were adopted in an attempt to reduce the growth of Medicare expenditures. Congress limited increases above the 1973 "prevailing charge" determination[10] to the extent justified by economic indexes reflecting changes in operating expenses of physicians and in earnings levels.

The Economic Index added as a limit to the "prevailing charge" generates a figure which most often falls below the physicians' "customary charge." This, together with the approximately 1½ year time lag before increases in actual fees are incorporated into the Medicare schedules results in substantial "reasonable charge" reductions in the payments made by Medicare on behalf of its beneficiaries. In the first quarter of 1977, 70.6% of the Part B claims were reduced.[11] This figure was increased to 74.0% in the second quarter of 1979.[12]

Along with this high percentage of reductions in Medicare claims comes a correspondingly high percentage of doctors now refusing to accept assignment of claims. Under Medicare's Part B program the physician decides whether to accept assignment (a concession Congress made to doctors in the negotiations which led to the pas-

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high enough to include 75% of the "customary charges" made for similar services in the same locality during the calendar year preceding the start of the fiscal year (beginning July 1) in which the claim is submitted for payment. 42 C.F.R. §405.504(a)(2)(ii).

[10]The "prevailing charge" for the fiscal year ending June 30, 1973 is the figure which is high enough to include 75% of the "customary charges" made between January 1, 1972 and December 31, 1972 See 42 U.S.C. §1392u(b), 42 C.F.R. §405.504(a)(3)(i).

[11]DHEW, HCFA, "Part B Reasonable Charge and Denial Activity Report: January-March 1977". (10/5/77)

[12]DHEW, HCFA, "Part B Reasonable Charge and Denial Activity Report: April-June, 1979." (9/28/79)

sage of the original Medicare law.[13] When assignment is accepted, the physician agrees to accept as full payment Medicare's allowed charge. Medicare pays the physician 80% of the allowed charge and the doctor can only bill the patient for the remaining 20%. If assignment is *not* accepted the Medicare beneficiary is responsible for 20% of the allowed charge as well as any amount which exceeds Medicare's reasonable charge determination.

In 1971, on 53.8% of the charges submitted for payment, doctors agreed to accept assignment; whereas, in 1978 that figure was down to 49.6%.[14] Because of this high rate of unassigned claims, nearly 70% of the Medicare beneficiaries had some liability; that is, money owed to the doctor for the difference between the physician's charge and the amount Medicare determined to be a "reasonable charge".[15]

Physician fee schedules such as those used by respondents upset the Medicare reimbursement scheme in several ways. By producing a mass of similar charges they essentially determine an increased prevailing charge for the next charge screen, while variations might have kept it down. This, of course, fuels the upward spiral in Medicare program costs. In turn, this annual increase in physicians' charges, combined with the time lag and economic index lid on Medicare reimbursement levels, produces reimbursement levels to beneficiaries that fall far short of

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[13] Felts, William R., M.D., "The Medicare fee index-everyone loses" – Medical Economics 86 (November 24, 1975).

[14] Ferry, Thomas P., Marian Gornich, Marilyn Newton, Carl Hackerman, "Physicians' Charges Under Medicare: Assignment Rates and Beneficiary Liability" 1 Health Care Financing Review 50 (Winter, 1980)

[15] Id. at 59.

the physicians' fees. As fewer and fewer physicians agree to accept assignment (perhaps to maintain their "fee schedules") elderly beneficiaries are forced to pay more for health care out of their own meager resources. Thus, the fee schedules themselves are the "anticompetitive characteristic" that distorts the economics of the Medicare program.

CONCLUSION

The Ninth Circuit's decision in this case creates conflicting standards of antitrust analysis in the circuit courts.[16] The uncertainty and confusion created by these conflicts may well encourage the establishment and maintenance of fee setting arrangements among health care providers, resulting in increased inflation in health costs. In order to prevent potential economic harm, the Supreme Court should issue a writ of certiorari to the United States Court of Appeals for the Ninth Circuit and resolve the important issues raised in this case.

DATED this 16th day of October, 1980.

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[16] See Petition at 17-18.